NHS England

Equality and Health Inequalities – Full Analysis - Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

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Contact Details for further information	england.medicines@nhs.net

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PART A: General Information

1. Title of project, programme or work:
Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

2. What are the intended outcomes?
Production of commissioning guidance, in partnership with NHS Clinical Commissioners, to advise CCGs on items which should not be routinely prescribed in primary care. This guidance updates original CCG guidance published in Nov 2017 for one item only (Rubefacients), and includes proposals for 8 further items.

Recommendations will categorise items as one of the following;

- Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns;
- Items which are clinically effective but where more cost-effective products are available, this includes products that have been subject to excessive price inflation; and/or
- Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.

3. Who will be affected by this project, programme or work?

- Staff – primarily primary care prescribers (e.g. GPs) who prescribe items identified within the commissioning guidance. Other staff groups (e.g. community pharmacy staff, secondary care clinicians) will also be impacted and will have a role to support patients in changes to their therapies.
- Patients – those who receive the prescription for items listed in the guidance.
- Partner organisations (e.g. NICE, MHRA etc.). We are using recommendations from partner organisations and they will have a role to play in implementation.

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?

The 9 defined items within the review could potentially be prescribed to anyone in the population requiring them to treat a medical condition, therefore covering all characteristics. The profile of people who are currently being prescribed each item can only be interrogated accurately for age and gender as national prescribing data available from the NHS Business Services Authority is only available for these two characteristics. We are therefore only able to demonstrate an accurate patient profile for individual medications for these two characteristics. However, we will also use data and responses collected from this consultation to further inform our view, prior to final commissioning guidance being published.

Overall this prescribing data for 2017/18 indicates that all items in the review are prescribed in almost equal levels to men and women.

Looking at the age profiles of patients prescribed medications in 2017/18 (see 5.1) the items prescribed for cardiovascular conditions and diabetes are more commonly prescribed in patients over the age of 65 years. Bath and shower emollient preparations and silk garments were prescribed most frequently to under 18 year olds, although bath and shower emollient preparations were prescribed in an almost equal proportion to the over 65 year age group.

A literature review was also undertaken to explore the research evidence on patient characteristics within disease areas rather than by individual medication. The aim of this exercise was to explore whether particular groups of patients may be affected by the proposals in a more general sense.

Full results can be seen in Appendix A. Overall the evidence reflects patterns seen in the prescribing data with no additional indication that specific groups of the population would be adversely impacted by the draft recommendations.

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

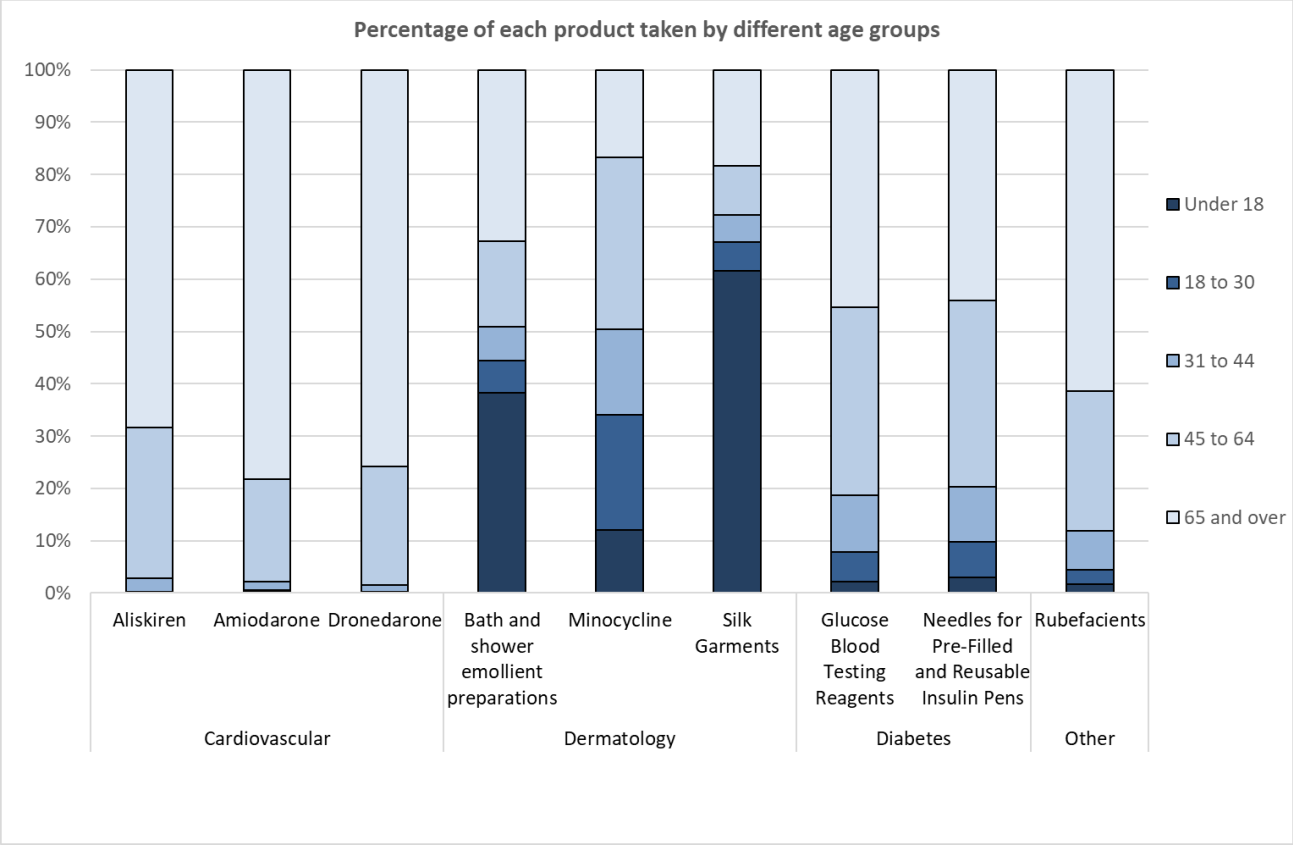
a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
e) If you cannot answer these questions what action will be taken and when?

5.1. Age

Does the equality group face discrimination in this work area?
As people get older they are more likely to be taking prescribed medications. However, there is no evidence to suggest that this prescribing is due to discrimination; rather this is likely due to increasing prevalence of various diseases related to increasing age.

Supporting Reference:
http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf

Figure 1. NHS BSA prescribing data 2017/18 by age (see appendix B for source data)



Could the work tackle this discrimination and/or advance equality or good relations?
Looking at the age profiles of patients prescribed the defined medications in 2017/18, the items related to cardiovascular issues, diabetes and the rubefacients were most frequently prescribed to adults aged 45 and over. Each of the cardiovascular medications were prescribed to the 65 year and over group in over 65% of cases with no patients aged 30 or less prescribed these items.

Bath and shower emollient preparations were prescribed most frequently to the under 18 group (38%) and the 65 and over group (33%). Silk garments were prescribed most frequently to the under 18 year old group (62%). Minocycline prescriptions were also prescribed in an even distribution across all age bands.

As people of increasing age take more prescribed medicines, older people are likely to receive more medicines included within our proposed guidance on *Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.* This guidance, if adopted by CCGs, should prompt review of these patients' treatments to optimise their treatment with more effective medicines.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain medicines which older people are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

The 3 month consultation will ensure engagement with any specific groups or charities to ensure that older people, who may be represented more, are adequately able to respond to the consultation.

5.2. Disability

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and disability so we cannot definitively assess fully at a national level. Studies have identified that people with disability are more likely to suffer from chronic pain however it is unknown if this is applicable to the specific patients taking the medications contained within this guidance.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people with disabilities.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain medicines which people with a disability are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.3. Gender reassignment

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and gender reassignment so we cannot definitively assess, at a national level, how many people will be affected.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people who have undergone gender reassignment.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain medicines which people who have undergone gender reassignment are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.4. Marriage and civil partnership

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and marriage/civil partnership so we cannot definitively assess, at a national level, how many people in a marriage/civil partnership will be affected. No link between prescribing and marriage/civil partnership has been identified.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people who are married or in a civil partnership.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain medicines which people who are married or in a civil partnership are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.5. Pregnancy and maternity

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and pregnancy/maternity so we cannot definitively assess, at a national level, how many people who are pregnant or who have had a baby will be affected.

None of the items proposed in the guidance are used for conditions that are closely related to pregnancy or maternity. We expect prescribers will use medication's *Summary of Product Characteristics* to inform treatment if any of these medicines are going to be used and prescribe accordingly.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people who are pregnant or who have had a baby.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain medicines which people who are pregnant or who have had a baby are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.6. Race

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and race so we cannot definitively assess, at a national level, how many people will be affected. Although there is an indication that the prevalence of type 2 diabetes is more prevalent for particular ethnic groups, the draft recommendation for these items is that a prescriber should offer a more cost-effective substitution rather than deprescribe.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all races.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by medications to patients of all races.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.7. Religion or belief

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and religion or belief so we cannot definitively assess, at a national level, how many people will be affected. No link between prescribing and religion or belief has been identified.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all religions and beliefs.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by medications to patients of all religions and beliefs.

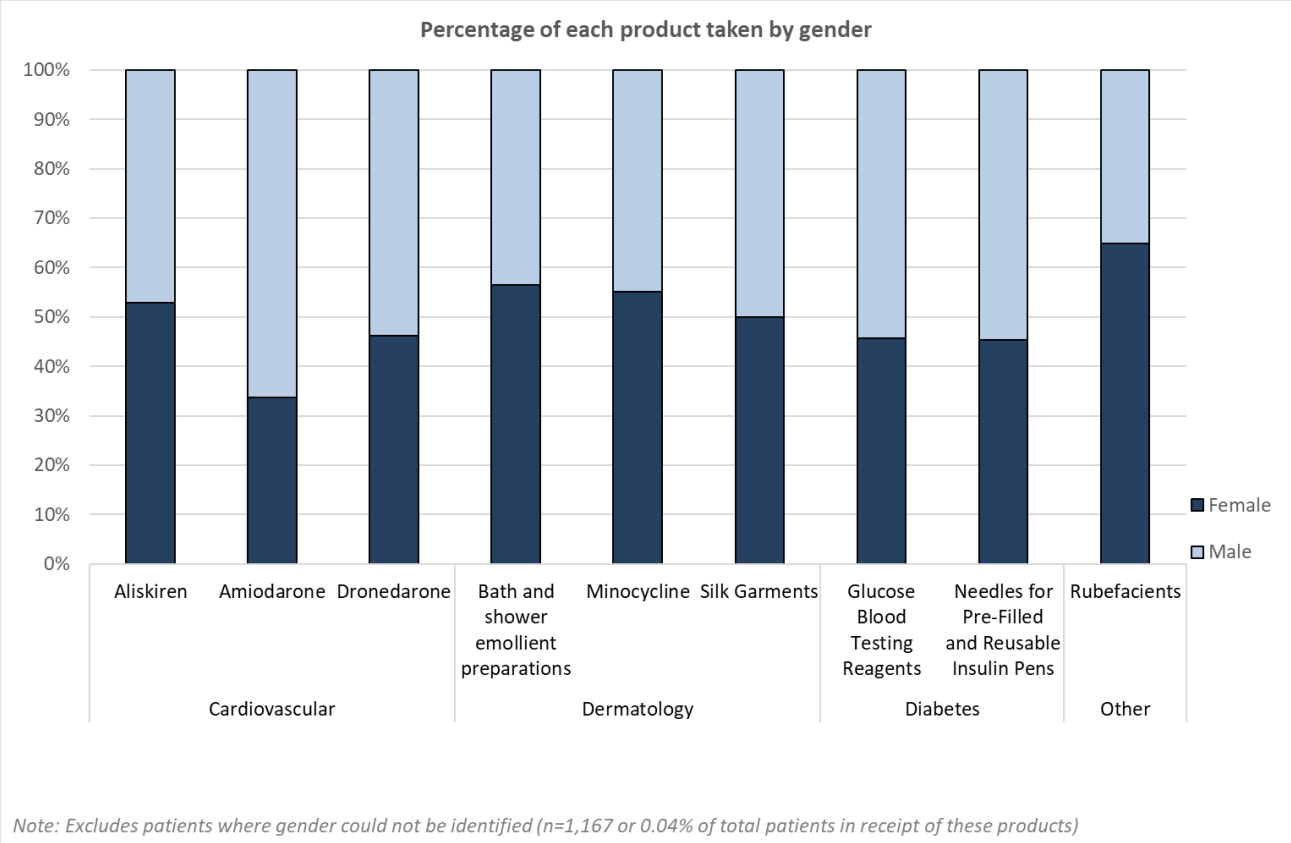
Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.8. Sex or gender

Does the equality group face discrimination in this work area?
Approximately 43% of men and 50% of women take at least one prescribed medicine. This proportion is higher among young women than young men, but increases more sharply with age in men than women. 22% of men and 24% of women report that they take at least three prescribed medicines; although this proportion increases with age it does not vary by sex.

Source:
http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf

Figure 2. NHS BSA prescribing data 2017/18 by gender (see appendix B for source data)



Note: Excludes patients where gender could not be identified (n=1,167 or 0.04% of total patients in receipt of these products)

Could the work tackle this discrimination and/or advance equality or good relations?
Overall this prescribing data for 2017/18 indicates that these medicines were prescribed in approximately equal proportions to women (50.4%) and men (49.6%). This indicates that medication reviews and potential deprescribing may be required equally for men and women.

This guidance, if adopted by CCGs, should prompt reviews of treatments meaning more people will receive reviews to optimise their treatment from the groups above.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
There is the potential that it could assist in potentially reducing harm caused by certain medicines which particular genders are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.9. Sexual orientation

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and sexual orientation so we cannot definitively assess, at a national level, how many people will be affected. There is no established link between the prescribing of items covered by this guidance and sexual orientation.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all sexual orientations.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by medications to patients of all sexual orientations.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

6. Implications of our work for the health inclusion groups listed below.
Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work[1], please answer the following questions:

f) Does the health inclusion group experience inequalities in access to healthcare?
g) Does the health inclusion group experience inequalities in health outcomes?
h) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?
i) Could the work assist or undermine compliance with the duties to reduce health inequalities?
j) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
k) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
l) If you cannot answer these questions what action will be taken and when?

[1] Our guidance document explains the meaning of these terms if you are not familiar with the language.

6.1. Alcohol and / or drug misusers

None of the medicines in the review are specifically used to support the treatment of patients suffering alcohol or drug misuse. There is no data available on the number of alcohol or drug users who are currently prescribed the medications in the review.

6.2. Asylum seekers and /or refugees

There is no data available on the number of asylum seekers and/or refugees who are currently prescribed the medications in the review.

6.3. Carers

There is no data available on the number of carers who are currently prescribed the medications in the review.

6.4. Ex-service personnel / veterans

There is no data available on the number of ex-service personnel / veterans who are currently prescribed the medications in the review.

6.5. Those who have experienced Female Genital Mutilation (FGM)

There is no data available on the number of those who have experienced Female Genital Mutilation (FGM) who are currently prescribed the medications in the review.

6.6. Gypsies, Roma and travellers

There is no data available on the number of Gypsies, Roma and travellers who are currently prescribed the medications in the review.

6.7. Homeless people and rough sleepers

There is no data available on the number of homeless people and rough sleepers who are currently prescribed the medications in the review.

6.8. Those who have experienced human trafficking or modern slavery

There is no data available on the number of those who have experienced human trafficking or modern slavery who are currently prescribed the medications in the review.

6.9. Those living with mental health issues

None of the medicines in the review are specifically used in the treatment of mental health conditions. There is no data available on the number of people with mental health conditions who are currently prescribed the medications in the review.

6.10.Sex workers

There is no data available on the number of sex workers who are currently prescribed the medications in the review.

6.11.Trans people or other members of the non-binary community

There is no data available on the number of trans people or other members of the non-binary community who are currently prescribed the medications in the review.

6.12.The overlapping impact on different groups who face health inequalities

There is no data available on different groups who face health inequalities who are currently prescribed the medications in the review.

7. Other groups that face health inequalities that we have identified.

Have you have identified other groups that face inequalities in access to healthcare?
Our consultation will be used to evaluate the impact on other groups which have not been identified.

Does the group experience inequalities in access to healthcare and/or inequalities in health outcomes?
N/A as above.

Short explanatory notes - other groups that face health exclusion.

As we research and gather more data, we learn more about which groups may be facing health inequalities.

If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

Yes	**No**	N/A
Complete section 8	Go to section 9	

N/A

8. Other groups that face health inequalities that we have identified.
Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes in relation to these other groups that face health inequalities?

Could the work undermine compliance with the duties to reduce health inequalities and, if so, what action should be taken to reduce any adverse impact?

Is the work going to help NHS England to comply with the duties to reduce health inequalities?
If you have identified other groups that face health inequalities please answer the questions below. You will only answer this question if you have identified additional groups facing important health inequalities

N/A

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.

9. Opportunities to reduce health inequalities through integrated services.

Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

Yes Go to section 10	**No** Go to section 11	Do not know

No

10. How can this work increase integrated services and reduce health inequalities?

Please explain below, in a few short sentences, how the work will encourage more integrated services that reduce health inequalities and which partners we will be working with.

N/A

PART D: Engagement and involvement

11. Engagement and involvement activities already undertaken.

How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs?

NHS England established a working group in partnership with NHS Clinical Commissioners with membership from their own organisations plus partner organisations. During Nov 2018 stakeholder engagement was undertaken with national patient organisations to contribute their views on the proposals including:

- National Voices
- Healthwatch
- Patient Association

Comments and suggestions were received on how to consult and reach further groups affected by the proposals. The consultation will also seek views from consultees on whether the proposal will impact particular groups.

12. Which stakeholders and equalities and health inclusion groups were involved?

NHS England, NHS Clinical Commissioners, Royal Pharmaceutical Society, NICE, Department of Health, PrescQIPP NHS Business Services Authority, Royal College of GPs, Academy of Medical Royal Colleges, National Voices, Patients Association, Healthwatch.

13. Key information from the engagement and involvement activities undertaken.

Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?

Stakeholders were broadly supportive of the work on the proposals for the initial list of 9 items and did not raise particular concerns about any of the protected characteristics for the defined list of medications.

14. Stakeholders were not broadly supportive but we need to go ahead.

If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?

N/A

15. Further engagement and involvement activities planned.

Are further engagement and involvement activities planned? If so what is planned, when and why?

NHS England is planning a full 3 month consultation to allow other groups and individuals to comment on the proposals. This will involve a web consultation survey plus further consultation activity (incl. in-person workshops) designed to ensure that people have the opportunity to provide their views. This will involve working with current stakeholders and other charities and patient groups.

PART E: Monitoring and Evaluation

16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work

Evaluation plan is being developed and consideration will be given to inequalities monitoring. For example we can monitor age and sex of all people on these medicines.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

NHS Business Services Authority (BSA) prescribing data 2017/18.

Please see appendix A for further evidence and literature references and sources.

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes	No

There is currently no nationally collected data for 7 of the 9 characteristics and additional health improvement groups for the individual medications in this review.

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

If you have identified important gaps and you have identified action to be taken, what action are you planning to take, when and why?

This is something that individual CCGs may have more insight on when looking at their local population data and will be encouraged to consider this as part of local consultation and impact assessment.

PART F: Summary analysis and recommended action		
20. Contributing to the first PSED equality aim. Can this work contribute to eliminating discrimination, harassment or victimisation?		
Yes	**No**	Do not know
If yes please explain how, in a few short sentences		
N/A		
21. Contributing to the second PSED equality aim. Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.		
Yes	No	Do not know
Currently patients could be receiving medications that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined medications this project encourages CCGs to implement policy that encourages review of patients taking these medications to ensure that their treatment is optimised, it can also reduce variation across the country. This enables patients to have access to the most effective medications to achieve the best outcomes. If more cost-effective options are utilised this frees up funding for other care and treatment to optimise wider population benefit and outcomes.		
22. Contributing to the third PSED equality aim. Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.		
Yes	No	Do not know
The Low Priority Prescribing clinical working group includes representatives from NHSCC, CCG medicines optimisation teams, NICE etc. We are also working with other stakeholders as described in question 12. The common aim to ensure that the CCG guidance developed supports CCGs in effective medicines optimisation for the population they serve. Fostering of good relationships will also be enhanced through engagement with a number of other stakeholders including charities and patient groups. The consultation also provides an opportunity for organisations, health professionals, patients and the public to be considered in the development of the CCG guidance.		
23. Contributing to reducing inequalities in access to health services. Can this policy or piece of work contribute to reducing inequalities in access to health services?		
Yes	No	Do not know

Currently patients could be receiving medications that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined medications this project encourages CCGs to implement policy that encourages review of patients taking these medications to ensure that their treatment is optimised. This enables patients to have access to the most effective medications to achieve the best outcomes. If more cost effective options are utilised this frees up funding for other care and treatment to optimise wider population benefit and outcomes.

Patients currently taking the medication will benefit. If CCGs implement the guidance once finalised, all patients being prescribed the included medications should be considered for medication reviews aimed to optimise their treatment and outcomes. There are also wider population gains than those who may benefit from the more efficient use of the money currently spent on low value medicines.

CCGs will need to consider this national impact assessment and the report form the national consultation when undertaking their own consultation and impact assessment as part of local implementation. This will help ensure that specific groups locally are not impacted adversely.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

Yes	No	Do not know

See section 23.

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

As section 23

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?

Action	Public Sector Equality Duty	Health Inequality	By when	By whom

Ensure that CCGs are encouraged to consider their local demographic and prescribing data available to ensure that local implementation decisions are effective and in line with legislation.	Yes	Yes	Post national consultation	CCGs
Support implementation with resources referenced in the guidance to support prescribers with deprescribing and offer of alternative medication where appropriate.	Yes	Yes	Post consultation	Project team LPP working group
Continue to gather intelligence to support review of the E&HI Impact assessment throughout the 3 month consultation period.	Yes	Yes	Nov 18 – Feb 19	Project team
Use initial insight from the consultation to develop the full equalities and health inequalities impact assessment.	Yes	Yes	Nov 18 – March 19	Project team
Continue to work with key stakeholders as described in the document to ensure that commissioning and clinical advice is fed into the guideline development alongside the consultation feedback.	Yes	Yes	Ongoing	Project team and stakeholders
Continue to engage and work with key patient groups and charities as part of the consultation to ensure groups identified in the document are provided with an opportunity to contribute towards the consultation and guidance development.	Yes	Yes	Ongoing	Project team and stakeholders
Via the consultation communications plan, promote the consultation effectively to ensure that groups suggested by the assessment as most effected have the opportunity to contribute to and shape the CCG guidance.	Yes	Yes	Nov 18 - Feb 19	Project team

Appendix A

Equalities and Health Inequalities Evidence Search

Cardiovascular conditions

The following evidence indicates that cardiovascular conditions such as hypertension are more prevalent among some of the protected characteristics (see below for details). The draft recommendations for these drugs seek to ensure that patients are offered a suitable alternative. Where required this would involve an MDT of other health professionals. There are no recommendations that result in patients being disadvantaged by offering no alternative or one that was not agreed collaboratively by the patient and clinician.

Prevalence
2015/2016 QOF recorded prevalence for hypertension Report hypertension prevalence rate as 13.8 per cent.

National CVD Intelligence network (2014) estimate expected prevalence per total population = 23.6% (includes undiagnosed estimates).

Age/sex
The relationship between age and the prevalence of hypertension differed between the sexes. The prevalence of survey-defined hypertension was significantly higher in men than women across each age group apart from those aged 65 and over.

Deprivation
Mirroring the trends found with equivalised household income, the age-standardised prevalence of hypertension was highest among those living in areas of high deprivation. Prevalence rose from 26% of men and 23% of women in the least deprived quintile to 34% of men and 30% of women in the most deprived quintile.
Knott C, Mindell J. Health Survey for England - 2011: Chapter 3, Hypertension. Leeds, UK: Health and Social Care Information Centre, 2012.

Dermatology

The following evidence does indicate that eczema is more prevalent in certain age groups. Atopic eczema affects more children than adults, this is estimated at 15 - 20% of children and 1 - 3% of adults worldwide.
Asher MI, Montefort S, Bjorksten B, Lai CK, Strachan DP, Weiland SK, Williams H: Worldwide time trends in the prevalence of symptoms of asthma, allergic rhinoconjunctivitis, and eczema in childhood: ISAAC Phases One and Three repeat multicountry cross-sectional surveys. Lancet 2006;368:733-743.

The following evidence from the Global Burden of Disease Project estimates the prevalence of acne at 9.4%. Studies evaluating sex differences have shown that acne is more prevalent in girls at younger age ranges, with increasing prevalence

in boys as they reach puberty. Following the teenage years, the prevalence in women again tends to be higher than in men.
https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.13462

Type 2 Diabetes

Public Health England data indicates that the prevalence of diabetes in England is 6.7% (QOF, 2016/17). Type 2 diabetes is more prevalent among those aged between 40 – 79 years. Data indicates that type 2 diabetes is slightly more prevalent in men than women.
https://fingertips.phe.org.uk/profile/diabetes-ft/data#page/0/gid/1938133138/pat/46/par/E39000030/ati/153/are/E38000010

Type 2 diabetes is much more common in ethnic minorities groups residing in developed countries; South Asian and African-Caribbean groups in the UK in particular have a high prevalence. Poverty has also been recognised as a contributor to prevalence of type 2 diabetes.
Riste L, Khan F, Cruickshank K. High prevalence of type 2 diabetes in all ethnic groups, including Europeans, in a British inner city: relative poverty, history, inactivity, or 21st century Europe? Diabetes Care2001;24:1377–83.

Chronic pain conditions – rubefacients

The following evidence indicates that the prevalence of chronic pain increases with age and was higher among women, and in people with disabilities, low incomes and low educational levels. The evidence also suggests that women may be more likely to report pain and that there are lots of other influencing factors which would affect the epidemiology of different types of chronic pain.

The draft recommendations for rubefacients ensure that patients would be offered a suitable alternative and where required, this would involve other relevant services. Recommendations do not result in patients being disadvantaged by offering no pain relief or an alternative that was not agreed collaboratively by the patient and clinician.

The estimated prevalence of chronic pain in the UK, derived from 7 studies, ranged from 35.0% to 51.3% (pooled estimate 43.5%, 95% CIs 38.4% to 48.6%). The prevalence of moderate-severely disabling chronic pain (Von Korff grades III/IV), based on 4 studies, ranged from 10.4% to 14.3%. 12 studies stratified chronic pain prevalence by age group, demonstrating a trend towards increasing prevalence with increasing age from 14.3% in 18–25 years old, to 62% in the over 75 age group, although the prevalence of chronic pain in young people (18–39 years old) may be as high as 30%. Reported prevalence estimates were summarised for chronic widespread pain (pooled estimate 14.2%, 95% CI 12.3% to 16.1%; 5 studies), chronic neuropathic pain (8.2% to 8.9%; 2 studies) and fibromyalgia (5.4%; 1 study). Chronic pain was more common in female than male participants, across all measured phenotypes.
Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies (Fayaz, 2016)

National pain audit (2013)
The prevalence of chronic pain is estimated at 8-60% of the population, depending on the definition. Severe pain is estimated at 11% for adults and 8% for children. Older age, sex, poor housing and type of employment (for example heavy manual work) are significant predictors of chronic pain in the community.
The epidemiology of chronic pain in the community (1999, Elliott et al)

A survey in Scotland (n = 3605) identified age, sex, housing tenure, and employment status as significant predictors of the presence of chronic pain in the community.
https://www.ncbi.nlm.nih.gov/pubmed/11166468

Chronic pain in Australia: a prevalence study (Blyth et al, 2001)
This study reports chronic pain prevalence in a randomly selected sample of the adult Australian population. Data were collected by Computer-Assisted Telephone Interview (CATI) (n = 17,543) Having chronic pain was significantly associated with older age, female gender, lower levels of completed education, and not having private health insurance. It was also strongly associated with receiving a disability benefit (adjusted OR=3.89, P<0.001) or unemployment benefit (adjusted OR=1.99, P<0.001); being unemployed for health reasons (adjusted OR=6.41, P<0.001); having poor self-rated health (adjusted OR=7.24, P<0.001); and high levels of psychological distress (adjusted OR=3.16, P<0.001).
http://ovidsp.uk.ovid.com/sp-3.25.0a/ovidweb.cgi?&S=HBIEPDNJPPHFFLLOFNGKOHEGHGHAAA00&Abstract=S.sh.91%7c99%7c1

Chronic pain: One year prevalence and associated characteristics, the HUNT pain study (Elsevier, 2013)
The total prevalence of chronic pain was 36% (95% CI 34-38) among women and 25% (95% CI 22-26) among men. The prevalence increased with age, was higher among people with high BMI, and in people with low income and low educational level.
http://ovidsp.uk.ovid.com/sp-3.25.0a/ovidweb.cgi?&S=HBIEPDNJPPHFFLLOFNGKOHEGHGHAAA00&Complete+Reference=S.sh.91%7c405%7c1

The prevalence of chronic pain in United States adults: Results of an internet-based survey (Johannas, 2010)
A cross-sectional, Internet-based survey was conducted in a nationally representative sample of United States (US) adults to estimate the point prevalence of chronic pain and to describe sociodemographic correlates and characteristics of chronic pain (n = 27,035). The weighted point-prevalence of chronic pain (defined as chronic, recurrent, or long-lasting pain lasting for at least 6 months) was 30.7% (95% CI, 29.8-31.7). Prevalence was higher for women (34.3%) than men (26.7%) and increased with age. Multiple logistic regression analysis identified low household income and unemployment as significant socioeconomic correlates of chronic pain. Chronic pain is prevalent among US adults and is related to indicators of poorer socioeconomic status

Gender considerations in the epidemiology of chronic pain (LeResche, 1999)

Indicates age and sex differences for different types of chronic pain conditions. Some indication that women may be more likely to report chronic pain, although this may not be a true indication of cases in the population.

Appendix B

Patients prescribed products by gender

(April 2017 - March 2018) *Source: NHS Business Services Authority*

	Number of identifiable patients				Percentage of identifiable patients			
	Female	**Male**	**Unknown**	**Total**	**Female**	**Male**	**Unknown**	**Total**
Aliskiren	1,410	1,253		**2,663**	52.9%	47.1%	0.0%	**100.0%**
Amiodarone	19,867	39,081	9	**58,957**	33.7%	66.3%	0.0%	**100.0%**
Bath and show er emollient preparations	486,695	374,071	792	**861,558**	56.5%	43.4%	0.1%	**100.0%**
Dronedarone	1,277	1,482		**2,759**	46.3%	53.7%	0.0%	**100.0%**
Glucose Blood Testing Reagents	568,143	673,188	204	**1,241,535**	45.8%	54.2%	0.0%	**100.0%**
Minocycline	5,385	4,399	7	**9,791**	55.0%	44.9%	0.1%	**100.0%**
Needles for Pre-Filled and Reusable Insulin Pens	297,006	357,465	80	**654,551**	45.4%	54.6%	0.0%	**100.0%**
Rubefacients	207,819	112,279	138	**320,236**	64.9%	35.1%	0.0%	**100.0%**
Silk Garments	3,752	3,745	6	**7,503**	50.0%	49.9%	0.1%	**100.0%**
Total	**1,591,354**	**1,566,963**	**1,236**	**3,159,553**	**50.4%**	**49.6%**	**0.0%**	**100.0%**

Notes: Patient counts are not unique across products. A patient is counted once per product but if they are prescribed multiple products then they will be counted multiple times. Patient gender will be unknown where the information could not be identified via the Personal Demographics Service (PDS) for an individual patient

Patients prescribed products by age band

(April 2017 - March 2018)

Source: NHS Business Services Authority

	Number of identifiable patients						Percentage of identifiable patients					
	Under 18	18 to 30	31 to 44	45 to 64	65 and over	Total	Under 18	18 to 30	31 to 44	45 to 64	65 and over	Total
Aliskiren		6	69	769	1,819	**2,663**	0.0%	0.2%	2.6%	28.9%	68.3%	**100.0%**
Amiodarone	135	197	907	11,547	46,171	**58,957**	0.2%	0.3%	1.5%	19.6%	78.3%	**100.0%**
Bath and show er emollient preparations	329,075	53,774	55,852	140,075	282,782	**861,558**	38.2%	6.2%	6.5%	16.3%	32.8%	**100.0%**
Dronedarone		5	39	622	2,093	**2,759**	0.0%	0.2%	1.4%	22.5%	75.9%	**100.0%**
Glucose Blood Testing Reagents	28,000	69,659	135,318	446,059	562,499	**1,241,535**	2.3%	5.6%	10.9%	35.9%	45.3%	**100.0%**
Minocycline	1,182	2,155	1,606	3,217	1,631	**9,791**	12.1%	22.0%	16.4%	32.9%	16.7%	**100.0%**
Needles for Pre-Filled and Reusable Insulin Pens	19,429	44,816	68,549	233,218	288,539	**654,551**	3.0%	6.8%	10.5%	35.6%	44.1%	**100.0%**
Rubefacients	5,386	8,688	24,233	85,418	196,511	**320,236**	1.7%	2.7%	7.6%	26.7%	61.4%	**100.0%**
Silk Garments	4,620	413	395	697	1,378	**7,503**	61.6%	5.5%	5.3%	9.3%	18.4%	**100.0%**
Total	**387,827**	**179,713**	**286,968**	**921,622**	**1,383,423**	**3,159,553**	**12.3%**	**5.7%**	**9.1%**	**29.2%**	**43.8%**	**100.0%**

Notes: Patient counts are not unique across products. A patient is counted once per product but if they are prescribed multiple products then they will be counted multiple times. The patients age is based on the maximum age of the patient, at the time of prescribing, during the financial year. Therefore a single patient will only appear in the results for one age group for a particular drug category